KAMALA D. HARRIS
Attorney General of California
ARMANDO ZAMBRANO
Supervising Deputy Attorney General
LANGSTON M. EDWARDS
Deputy Attorney General
State Bar No. 237926
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 620-6343
Facsimile: (213) 897-2804
Attorneys for Complainant

BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TWIN PHARMACY, INC. dba** **DABNEY PHARMACY** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 and **Robert Rothman** 4682 Warner Avenue #C-115 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondents.	Case No. 4445 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy (Board), Department of Consumer Affairs.

2. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License Number RPH 30759 to Robert Rothman (Respondent Rothman). The Pharmacist License was in

full force and effect at all times relevant to the charges herein and will expire on May 31, 2014, unless renewed.

3. On or about June 14, 2004, the Board of Pharmacy issued Pharmacy Permit Number PHY 46745 to Twin Pharmacy, Inc. dba Dabney Pharmacy; Robert Rothman, Pharmacist-in-Charge; Shlomo Rechnitz, President; Denise Wilson-Ruane, Secretary (Respondent Dabney). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on June 1, 2014, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 118, subdivision (b), provides in pertinent part that the suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

6. Section 4300 states, in pertinent part:

"(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper."

STATUTORY PROVISIONS

7. Section 4306.5 states:

"Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

8. Section 4040 provides in pertinent part:

"(a) 'Prescription' means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either Section 4052.1 or 4052.2.

...

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail."

9. Section 4063 states:

"No prescription for any dangerous drug or dangerous device may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed."

10. Section 4059 subdivision (a) states:

"A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

11. Section 4081 provides in pertinent part:

"(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy ... or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

(b) The owner, officer, and partner of a pharmacy ... shall be jointly responsible, with the pharmacist-in-charge or designated representative-in-charge, for maintaining the records and inventory described in this section."

12. Section 4104 provides in pertinent part:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs.

(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy."

13. Section 4169 states, in pertinent part:

"(a) A person or entity may not do any of the following:

...

(3) Purchase, trade, sell, or transfer dangerous drugs that the person knew or reasonably should have known were misbranded, as defined in Section 111335 of the Health and Safety Code."

REGULATORY PROVISIONS

14. California Code of Regulations, Title 16, section 1718 states:

"Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory."

15. California Code of Regulations, Title 16, section 1714 provides in pertinent part:

"(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice of pharmacy.

...

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist."

16. California Code of Regulations, Title 16, section 1717 provides in pertinent part:

"(b) In addition to the requirements of Business and Professions Code section 4040, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself. All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of this subsection."

COST RECOVERY

17. Business and Professions Code section 125.3 provides in pertinent part, except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

DRUG DEFINITIONS

18. Hydrocodone with acetaminophen, trade name **Vicodin ES**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

19. Acetaminophen with codeine, trade name **Tylenol #3**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business

and Professions Code Section 4022.

20. Promethazine with codeine, trade name **Phenergan with Codeine**, is a Schedule V controlled substance pursuant to Health and Safety Code Section 11058 and a dangerous drug per Business and Professions Code Section 4022.

BACKGROUND FACTS

21. On or around April 8, 2011, Board Inspectors reviewed the Controlled Substances Utilization Review and Evaluation System (CURES)[1] data for Respondent Dabney, located at 11115 S. Main Street, Los Angeles, CA 90061. The CURES data revealed that Respondents Dabney and Rothman were 18 months late in filing CURES reporting.

22. On or around April 11, 2011, a search warrant was performed at Respondent Dabney's location based on information that prescription drugs being dispensed by Respondents Dabney and Rothman were found to be unlawfully taken into Mexico and sold.[2]

23. On or around June 15, 2011, Board Inspectors performed an audit of the three most frequently filled prescriptions at Respondents Dabney and Rothman during the time period between 8/4/09 and 4/11/11: Vicodin ES, Tylenol #3 and Promethazine with Codeine.

//

//

[1] The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was since amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

[2] In 2011, a San Diego pharmacist informant led law enforcement authorities to Milton Farmer, who officials suspected of smuggling prescription drugs. A search of Farmer's trashcan in Oceanside, CA revealed empty prescription bottles from Respondent Dabney. Investigations concluded that Dr. Tyron Reece wrote prescriptions for patients that he did not actually examine and that Anthony "Sam" Wright would get these prescriptions filled at Respondent Dabney. Mr. Wright would then transport the prescription medication from Los Angeles to San Diego and deliver them to couriers like Milton Farmer. Mr. Farmer and other couriers would cross the border with the prescription medication strapped to their body and sell the drugs to pharmacies in Mexico.

24. An audit of Respondent Dabney revealed the following during that time period:

	VICODIN ES	TYLENOL #3	PROMETHAZINE with Codeine
Total Purchased	290,200	227,400	1,954,560
Total Dispensed	271,028	221,724	1,793,255
Amount on hand as of 4/11/11	613	1767	25,920
Total Missing (Loss)	18,559 tablets	3909 tablets	135,385 ml

25. On or around June 2011, Board Inspectors obtained an older CURES report submitted by Respondents Dabney and Rothman to review 13 patients' controlled substance drug treatment and therapy regime during the time period between 2007 and 2009.

26. Based on the 13 patient profiles reviewed (CURES patients), Board Inspectors learned that Respondents Dabney and Rothman filled a total of 119 prescriptions during that time period, without authorization by a prescribing physician.

27. The Board subsequently attempted to obtain additional information from the 13 patients relating to services they received from Respondents Dabney and Rothman. The Board received no responses from any of the 13 patients.

28. However, a review of 6 patient profiles revealed the following:

a. PATIENT #41 ZA[3]

DRUG	AMOUNT	DATE OF FILL
Hydrocodone/APAP ES	60	3/13/09
Hydrocodone/APAP ES	60	4/6/09
Hydrocodone/APAP ES	60	4/23/09
Hydrocodone/APAP ES	60	5/8/09

[3] Patient initials are used to protect confidentiality here, and in each instance throughout the Accusation.

Hydrocodone/APAP ES	60	6/3/09
Hydrocodone/APAP ES	60	6/22/09
Hydrocodone/APAP ES	100	12/10/10
Hydrocodone/APAP ES	100	1/10/11
Hydrocodone/APAP ES	100	2/10/11
Hydrocodone/APAP ES	100	3/14/11

Summary: Patient received a quantity of 60 Hydrocodone/APAP ES within quick succession during the time period between 4/6/09 and 5/9/09 for a total of 180 tablets in just over 30 days.

b. PATIENT #43 EA

DATE	DRUG	PRESCRIBING PHYSICIAN
4/2005	Tylenol #3	Habbestad[4]
6/2005	Promethazine/Codeine	Reece
7/2005	Tylenol #3	Habbestad
7/2005	Promethazine/Codeine	Apusen
7/2005	Vicodin ES	Ayodele
8/2005	Vicodin ES	Apusen
8/2005	Vicodin ES	Ayodele
9/2005	Vicodin ES	Apusen
9/2005	Promethazine/Codeine	Rojas

[4] On or around October 10, 2008, Robert Habbestad received a Public Reprimand for failing to maintain adequate and accurate medical records and failing to record information relating to patient examinations in The Matter of the Accusation Against Robert Habbestad, M.D., OAH No. L2006120274.

10/2005	Promethazine/Codeine	Habbestad
10/2005	Vicodin ES	Ayodele
11/2005	Promethazine/Codeine	Rojas
11/2005	Vicodin ES	Rojas
12/2005	Promethazine/Codeine	Rojas
12/2005	Vicodin ES	Rojas
1/2006	Vicodin ES	Christian
3/2006	Vicodin ES	Apusen
3/2006	Promethazine/Codeine	Rojas
4/2006	Vicodin ES	Ware
6/2006	Promethazine/Codeine	Estiandan
8/2006	Vicodin ES	Rojas
8/2006	Promethazine/Codeine	Rojas
8/2006	Vicodin ES	Estiandan
10/2007	Vicodin ES	Chickey[5]
10/2007	Promethazine/Codeine	Chickey
1/2008	Vicodin ES	Chickey
3/2008	Vicodin ES	Chickey
3/2008	Promethazine/Codeine	Chickey
5/2008	Vicodin ES	Ware
5/2008	Promethazine/Codeine	Chickey
6/2008	Promethazine/Codeine	Chickey

[5] Anna Lourdes Armada Chickey, M.D. DEA Registration is currently under investigation by DEA, Los Angeles Region.

8/2008	Promethazine/Codeine	Reece
8/2008	Vicodin ES	Reece
9/2008	Promethazine/Codeine	Reece
9/2008	Vicodin ES	Habbestad
9/2008	Vicodin ES	Ayodele
10/2008	Promethazine/Codeine	Reece
10/2008	Vicodin ES	Reece
11/2008	Vicodin ES	Reece
1/2009	Promethazine/Codeine	Chickey
1/2009	Vicodin ES	Chickey
2/2009	Promethazine/Codeine	Chickey
7/2009	Vicodin ES	Chickey
7/2009	Promethazine/Codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	Promethazine/Codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	Promethazine/Codeine	Chickey
11/2009	Promethazine/Codeine	Reece
11/2009	Vicodin ES	Chickey

Summary: Patient doctor shopped by using several different prescribers to obtain the same medications. In 2006, the patient used 4 different doctors to obtain Vicodin ES and Promethazine/Codeine. In 2008, the patient used 5 different doctors to obtain Vicodin ES and Promethazine/Codeine. Respondents Dabney and Rothman failed to document why the patient

was seeing multiple prescribers for the same drugs.

c. PATIENT #44 JB

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/2008	Tylenol #3	Habbestad
3/2008	Tylenol #3	Habbestad
5/2008	Tylenol #3	Habbestad
5/2008	Vicodin ES	Ayodele
7/2008	Tylenol #3	Habbestad
8/2008	Vicodin ES	Ayodele
9/2008	Tylenol #3	Ayodele
11/2008	Tylenol #3	Mays[6]
12/2008	Tylenol #3	Habbestad

Summary: Patient received both Vicodin ES and Tylenol #3, both for pain. There is no documentation showing that the pharmacist consulted with the prescribing physicians to determine if both medications were appropriate or correctly prescribed for pain. In addition, the patient used multiple prescribers to receive the same medications in the same month.

//

//

//

[6] On or around July 23, 2006, James Arthur Mays received a Public Reprimand for failing to maintain adequate and accurate medical records and in The Matter of the Public Letter of Reprimand Issued to James Arthur Mays, M.D., Case No. 06-2003-147182.

d. PATIENT #46 YD

Summary: During the time period between December 2004 and 2012, approximately 123 of a total of 151 prescriptions written for the patient were for controlled substances. The patient received Promethazine/Codeine, Vicodin ES, Soma, Xanax, Tylenol #3, Valium, ampicillin, Keflex, Ibuprofen, Pepcid and Methocarbamol. In 2009 and 2010, the patient obtained mostly controlled substance prescriptions from Drs. Estiandan, Al-Bussam, and Chickey – all of whom have had actions taken against their medical licenses or are currently under investigation. Respondents Dabney and Rothman failed to inquire about why the patient has had a cough and pain for 8 years and why so many different doctors were sought for these prescriptions.

e. PATIENT #50 YG

Summary: On or around April 13, 2009, Respondents Dabney and Rothman filled a prescription for 240ml of Promethazine/Codeine for this patient. On or around April 20, 2009, Respondents Dabney and Rothman filled a second prescription for 240ml of Promethazine/Codeine for his patient. The maximum recommended dose is 30ml/day. The patient would not have been able to complete one prescription within seven days. Respondents Dabney and Rothman failed to document that the patient was not receiving a benefit from the medication, nor did they document contacting the prescribing physician to inform him/her that the medication was not working.

//

//

//

//

//

f. PATIENT #53 TH

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/8/07	Promethazine/Codeine	Fishman
1/17/07	Promethazine/Codeine	Ayodele
3/8/07	Promethazine/Codeine	Lin

Summary: Within two months, the patient received 3 prescriptions for Promethazine/Codeine from 3 different prescribing physicians, the second arriving merely 9 days after the first. The maximum recommended dose is 30ml/day. There is no documentation that Respondents Dabney and Rothman contacted the prescribing physicians regarding deviation from the recommended dosage or contacted the patient regarding use of the medication.

29. On or around November 10, 2011, Board Inspectors requested that Respondents Dabney and Rothman produce a copy of its office policy relating to employee impairment and theft in the workplace.

30. Respondents Dabney and Rothman failed to produce a policy pursuant to the Board's request.

31. Respondent Rothman admitted receiving a "large number of verbal orders and writing a large number of telephone prescription documents." When asked to produce written records of telephone orders, Respondent failed to produce compliant documentation which require name of patient, date of request, name, address, telephone number, license number and DEA number of the prescriber, and drug type, quantity and directions for use.

32. On or around August 2012, Board Inspectors reviewed the profiles of

approximately 40 patients whose names were found on empty prescription bottles in a trashcan and were identified as having received prescription drugs filled by Respondents Dabney and Rothman (*See* footnote 2, infra).

33. A review of the 40 patient profiles revealed that Respondents Dabney and Rothman refilled several duplicate prescriptions for the same patient on the same day.

34. The records also revealed that Respondents Dabney and Rothman refilled three prescriptions for the same patient, without authorization from the prescribing physician.

35. A review of the 40 patient profiles established that 94.2% of all prescriptions filled by Respondents Dabney and Rothman were for either one of three medications: hydrocodone/apap, Phenergan with codeine or alprazolam (Xanax) (34.9%, 35.5% and 24.6% respectively), all of which are controlled substances.

36. The records showed no prescription treatment for any other diagnosis (i.e. blood pressure, diabetes, cholesterol, etc.).

37. Dr. Carlos Estiandan (Dr. Estiandan) wrote approximately 66.1% of the prescriptions (866 total prescriptions) for 24 of the 40 patients identified.[7]

38. Of all prescriptions written by Dr. Estiandan, 283 prescriptions were for promethazine with codeine and 276 were for hydrocodone/apap.

39. Prescriptions written by Dr. Estiandan were filled on 221 different days, many of which were filled by Respondents Dabney and Rothman on the same day, in bulk.

40. Sometime on or around February 10, 2009, the Medical Board of California, Department of Consumer Affairs filed an Accusation against Dr. Estiandan alleging among other

[7] Dr. Carlos Estiandan, was arrested and found guilty on March 15, 2010 of 13 counts of unlawfully writing controlled substance prescriptions without a legitimate medical purpose and outside the usual scope of practice in *The People of the State of California v. Carlos Estiandan*, Los Angeles County Superior Court Case No. BA34703 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). On or around September 9, 2009, Dr. Estiandan surrendered his license to practice medicine the state of California.

things, repeated acts of negligence, violation of drug laws, prescribing without appropriate examination of medical condition and prescribing to an addict.[8]

41. Shortly after Dr. Estiandan was arrested and ultimately surrendered his license to practice medicine, Dr. Tyron Reece (Dr. Reece) began writing prescriptions for Dr. Estiandan's patients.

42. Dr. Reece wrote approximately 369 prescriptions for 38 of the 40 patient during the period between October 2, 2009 – April 11, 2011.

43. One hundred percent of Dr. Reece's prescriptions were written for either promethazine with codeine, hydrocodone/apap or alprazolam (Xanax).[9]

44. Dr. Estiandan and Dr. Reece wrote a combined 94.2% of all prescriptions attributed to the 40 patient prescriptions found in the trashcan and identified as having received prescription drugs filled by Respondents Dabney and Rothman.

45. Dr. Estiandan's and Reece's prescriptions for the 40 patients were filled by Respondents Dabney and Rothman even though the following facts appeared to exist: The patients all had similar diagnosis and saw the same two doctors; The patients received the same drug combinations in the same quantities/amounts irrespective of age; The drugs prescribed are highly abused and have high street value; In many instances, the patient did not reside in close proximity to Respondent Dabney or to either physician; All patients were prescribed controlled substances and none received prescriptions for blood pressure, cholesterol or diabetes; The patients all had the same medical condition (cough, anxiety and pain) although neither Dr. Estiandan or Dr. Reece are pain specialists or pulmonologists (chronic bronchitis) or psychiatric

[8] Administrative action was brought in The Matter of the Accusation Against Carlos Estiandan, M.D., Before the Medical Board of California Department of Consumer Affairs State of California, File No. 17-2004-162750, OAH No. 2009020501 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). Dr. Estiandan surrendered his license to practice medicine in the state of California on or around September 9, 2009.

[9] Dr. Reece surrendered his DEA registration on July 8, 2011 in lieu of disciplinary action.

specialists (anxiety); The patients did not drop off their own prescriptions to be filled; All prescriptions were paid for in cash, and not by insurance; Dr. Estiandan was arrested and charged relating to unlawfully prescribing medication; All of Dr. Estiandan's patients were transferred to Dr. Reece after Dr. Estiandan was arrested, even though the physicians' respective offices are approximately 20 miles apart.

46. When interviewed by Board Inspectors relating to the 40 patients identified, Respondent Rothman admitted that he did not know anything about the patients and failed to provide any specific information.

47. Respondent Rothman admitted that he defers to the doctor's judgment exclusively in lieu of personally verifying patient prescriptions. Respondent Rothman also admitted that he permits his pharmacy staff makes conclusive determinations regarding the legitimacy of patient prescriptions.

48. Respondent Rothman admitted that did not use CURES reports or his own professional judgment when filling patient prescriptions.

49. Respondent Rothman admitted that he did not know about or act according to his corresponding responsibility when filling patient prescriptions.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Inappropriate Exercise of Education)

50. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (a) in that Respondent engaged in acts or omissions that involve the inappropriate exercise of his education, training or experience as a pharmacist. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

//

//

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Exercise Best Judgment)

51. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (b) in conjunction with California Code of Regulations, Title 16, sections 1714 and 1718 and Health and Safety Code sections 11056 and 11058 in that Respondent engaged in acts or omissions involving failure to exercise his best professional judgment or corresponding responsibility with regard to dispensing or furnishing controlled substances or dangerous drugs with regard to the provision of services. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Review Patient Records)

52. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (c) in that Respondent engaged in acts or omissions that involve failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Maintain Patient-Specific Information)

53. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (d) in that Respondent engaged in acts or omissions that involve failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function. Complainant incorporates by reference paragraphs 21 – 22, as if fully set forth herein.

//

//

//

FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with the Prescription Requirements)

54. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4040 in conjunction with California Code of Regulations, Title 16, section 1717 in that Respondent failed to comply with the requirements of orally transmitted prescriptions, which require, among other items, the name(s) and address(es) of patients, quantity of the drug prescribed and directions for use, date of issue. Complainant incorporates by reference paragraphs 31, as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with the Prescription Refill Requirements)

55. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4063 in that Respondent failed to comply with the requirements of a prescription refill. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prescription)

56. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4059 in conjunction with Health and Safety Code sections 11056 and 11058 in that Respondent furnished controlled substances dangerous drugs without a prescription. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain a Policy Relating to Theft or Impairment)

57. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4104 in that Respondent failed to have written policies and procedures for addressing chemical, mental or physical impairment as well as theft, diversion among licensed individuals

employed by the pharmacy. Complainant incorporates by reference paragraphs 29 – 30, as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Trading, Selling and/or Transferring Misbranded Drugs)

58. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4169 in that Respondents purchased, traded, sold or transferred dangerous drugs that Respondents knew or reasonably should have known were misbranded. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

DISCIPLINE CONSIDERATIONS

59. To determine the degree of discipline, if any, to be imposed on Respondent Robert Rothman, Complainant alleges that on or about January 31, 1987, in a prior disciplinary action entitled In the Matter of the Accusation Against Robert Rothman before the Board of Pharmacy, in Case Number 1217 Respondent's license was revoked and revocation was stayed and Respondent Rothman was placed on three (3) years probation with terms and conditions. In addition, Respondent's Pharmacist License Number RPH 30759 was suspended for ninety (90) days.

60. The circumstances are that on or around November 28, 1983, Respondent was convicted on his guilty plea of violating Business and Professions Code § 4227 [furnishing or dispensing drugs without a prescription] Penal Code §§ 64/496 [attempted receipt of stolen property] in the matter *The People of the State of California v. Robert Bruce Rothman*, Orange Co. Super. Court, Case No. C-1554 (1983).

61. That decision is now final and is incorporated by reference as if fully set forth.

//

//

//

//

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit Number PHY 46745, issued to Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy; Shlomo Rechnitz; Denise Wilson-Ruane;

2. Revoking or suspending Pharmacist License Number RPH 30759, issued to Respondent Robert Rothman;

3. Ordering Respondents Dabney Pharmacy and Robert Rothman to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 12/2/13

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

LA2012507854
51356186.docx